Community Circle of Care

A partnership among Child Health Specialty Clinics (Title V), the Center for Disabilities and Development, the Department of Human Services, and several other community partners.

Debra Waldron, MD, MPH, FAAP
Vice Chair Child Health Policy, University of Iowa
Director and Chief Medical Officer,
Child Health Specialty Clinics,
Debra-Waldron@uiowa.edu
319.356.1117

Mental Health Needs – Children/Youth

Quick Facts

- 1 in 5 children birth to 18 has a diagnosable mental health disorder.
- 1 in 10 youth has serious mental health problems that are severe enough to impair how they function at home, in school, or in the community.
- Onset of major mental illness may occur as early as age 7 - 11 years
- Roughly ½ of all lifetime mental health disorders start by mid-teens.

NCCP April 2010

National Center for Children in Poverty, 4/2011

Children who have one or more emotional, behavioral, or developmental conditions (Percent) – 2007

National range 12-20%; IA 17%

i.e. Autism, dev delays, ADD/ADHD, behavior/conduct problems, anxiety/depression

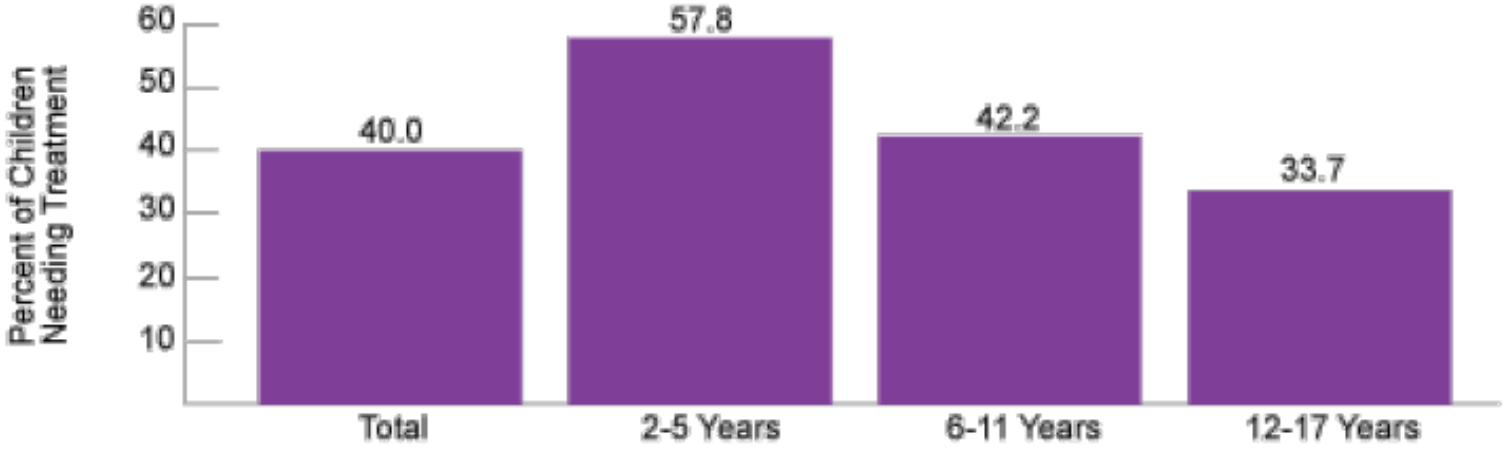
Scale: 12% - 20%

United States	15%
Alabama	18%
Alaska	15%
Arizona	14%
Arkansas	19%
California	13%
Colorado	13%
Connecticut	16%
Delaware	19%
Florida	16%
Georgia	12%
Hawaii	13%
Idaho	14%
Illinois	13%
Indiana	18%
Iowa	17%
Kansas	16%
Kentucky	18%
Louisiana	19%
Maine	20%
Maryland	18%
Massachusetts	18%
Michigan	17%
Minnesota	14%
Mississippi	15%
Missouri	16%
Montana	17%
Nebraska	15%
Nevada	13%
New Hampshire	17%
New Jersey	14%
New Mexico	14%
New York	14%
North Carolina	20%
North Dakota	16%
Ohio	20%
Oklahoma	18%
Oregon	16%
Pennsylvania	17%
Rhode Island	19%
South Carolina	15%
South Dakota	13%
Tennessee	16%
Texas	12%
Utah	14%
Vermont	20%
Virginia	16%
Washington	17%
West Virginia	18%
Wisconsin	15%
Wyoming	17%
District of Columbia	15%
Puerto Rico	N.A.
Virgin Islands	N.A.

Mental Health Needs - Children

Children Aged 2–17 Years Who Needed but Did Not Receive* Mental Healthcare/Counseling in the Past Year, by Age, 2007

Source (I.7): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



Both need for treatment and receipt of treatment are based on parent report.

Nationwide vs. Iowa Mental Health Profile 2007

	Nationwide	Iowa
		%
Overall Prevalence		
Percent of children aged 2-17 years who have one or more emotional, behavioral, or developmental conditions*	11.3	10.6
Prevalence by Age**		
Age 6-11 years	12.1	13.1
Age 12-17 years	14.9	13.6
Prevalence by Sex		
Male	14.5	12.0
Female	7.9	9.2
Prevalence by Poverty Level***		
0-99% FPL (Federal Poverty Level)	15.5	17.8
100-199% FPL	12.7	6.8
200-399% FPL	9.9	12.4
400% FPL or more	9.2	7.9
Prevalence by Insurance Type		
Public	17.5	17.6
Private	9.0	8.0
Percent of children age 2-17 years with emotional, behavioral, or developmental conditions:		
Who have two or more emotional, behavioral, or developmental conditions	40.3	40.5
Who receive coordinated, ongoing, comprehensive care within a medical home	40.2	54.3
Whose health insurance is adequate to meet their needs	70.6	68.5
Who received mental health treatment or counseling in the past year	45.6	57.6

Iowa's Vision for an Integrated System of Care for Children with Special Healthcare needs.

- **Children's Oversight Commission Model**
  - Lighthouse – no wrong door
  - Navigators
  - Coordinated care plan of services, supports, and resources
  - Governance structure
  - Family Driven
  - Youth Guided

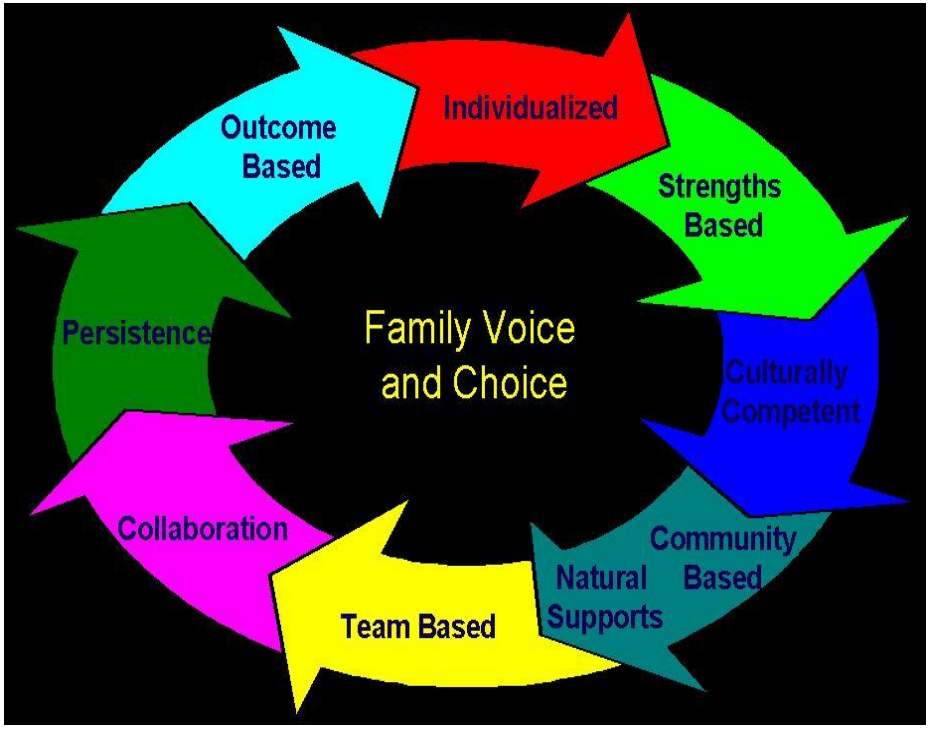
- **Community Circle of Care Model**
  - Information and referral - No wrong door
  - Care coordinators
  - Individualized and coordinated Wrap Around plan for services and supports
  - Governance structure including local and regional advisory boards
  - Family Driven
  - Youth Guided

Community Circle of Care Vision

Children and youth with emotional and behavioral challenges and their families have access to a broad base of community systems of care, that wraps around them to support their health and build resiliency so they can reach their greatest potential

SYSTEM OF CARE VALUES

- *Family Voice and Choice*
- *Youth Voice and Choice*
- *Strength Based*
- *Culturally Competent*
- *Team Based*
- *Natural Supports*
- *Individualized*
- *Collaboration*
- *Community Based*
- *Outcome Based/Data Driven*
- *Persistence*



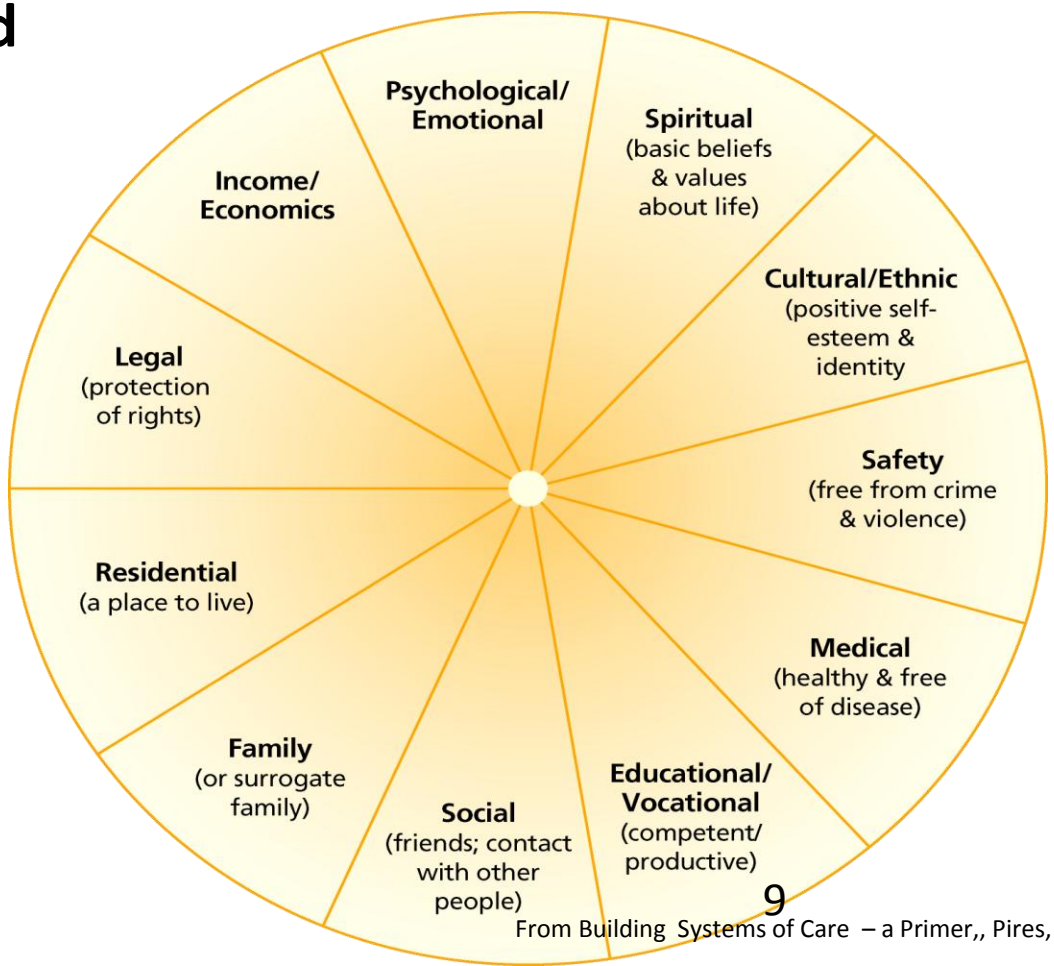
From Building Systems of Care – a Primer,, Pires, 2002

CCC/CHSC System of Care includes 4 components
Family Support
Care Coordination
Clinical Care – Holistic Assessment
Systems Building/Infrastructure

CCC Model of Care
Medical Assessment + Social Supports

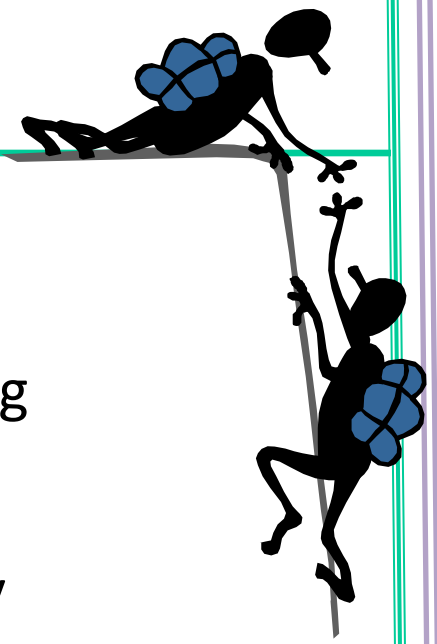
- **Family Team Meeting**
  - including natural supports
- **Medical Assessment and Diagnosis** (if needed)
  - Multi-disciplinary team
  - Tele-medicine
  - Medication management
  - Evidenced Based Practice Parameters
  - **Return to medical home**
- **Care Coordination**
  - Linkage to community services
  - Social supports

Life Domain Areas - addressed in medical assessment



From Building Systems of Care – a Primer,, Pires, 2002

Family Team Meeting



- Natural Supports identified
- Agenda set by family/youth
- Community supports the family team meeting concept, (providers attend and provide input, they offer to host meetings at their location)
- Families report feeling empowered - like they really have choices.
- Barriers to services, or service gaps discovered during family team meetings, are taken to local community advisory meetings for solution focused discussion among stakeholders including family, youth, providers, community members, and other interested stakeholders.

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CHILD HEALTH SPECIALITY CLINICS
COMMUNITY CIRCLE OF CARE

Care Coordination

- Care Coordinators are responsible to navigate the service systems and link the family to needed services. Care Coordinators are nurses, social workers and Family Navigators:
  - Lead family team meetings
  - Develop individualized care plan
  - Research resources and make referrals
  - Assist with insurance/waiver/support paperwork
  - Assist patient/family in coordinating appointments, IEP meetings, etc
  - Assist patient/family in finding funding for ancillary services like respite, mentoring, and transportation

Social Supports for Families and Youth

Caregiver and family education

- Family Navigators provide parent to parent support.
- Parenting classes
- Crisis de-escalation strategies

Support groups

- Parent to parent support groups and activities
- Military family support groups and activities
- Led by CCC staff and/or a local parent who has been mentored and trained
- These groups provide camaraderie and friendship

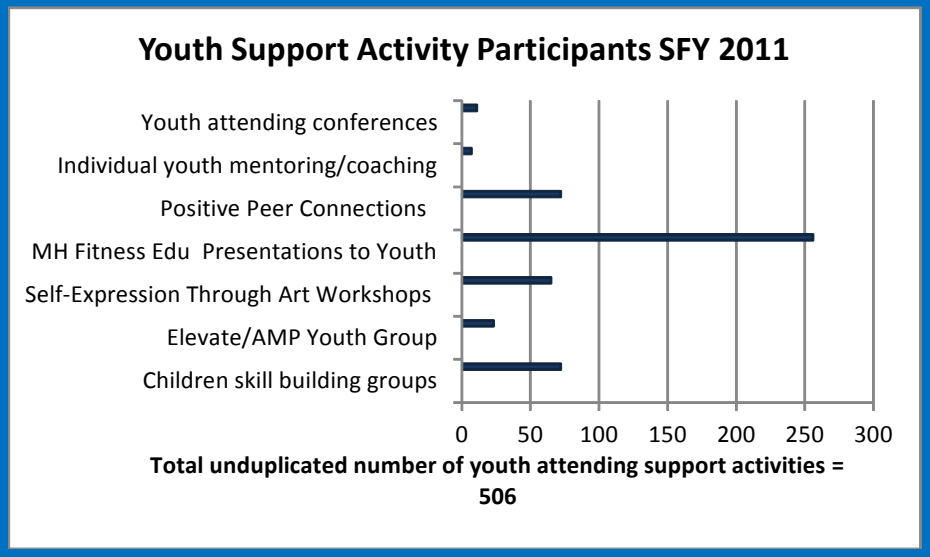
Youth Expression , prevention and awareness activities

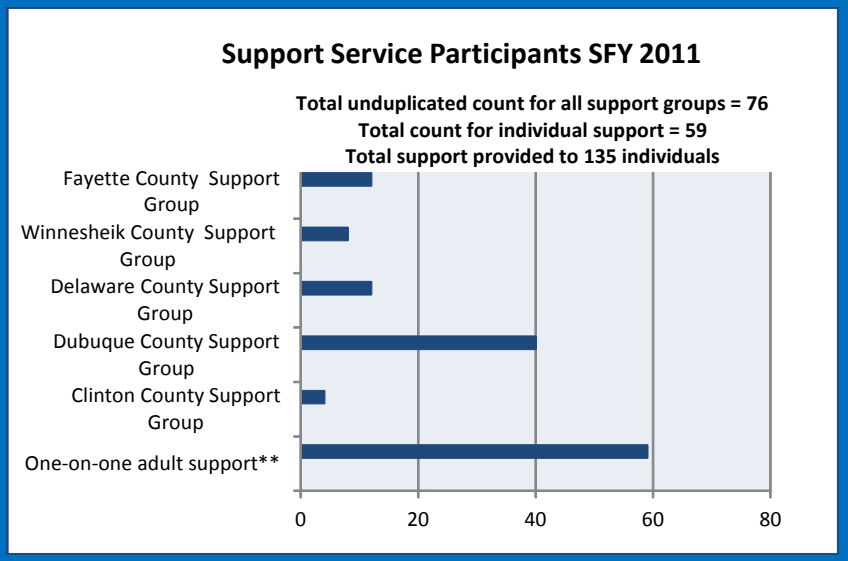
- Art Expression
- Digital Story Telling
- Youth Advisory Board
- Dare to Dream events
- Leadership activities
- Advocacy teaching
- MH fitness education presentations

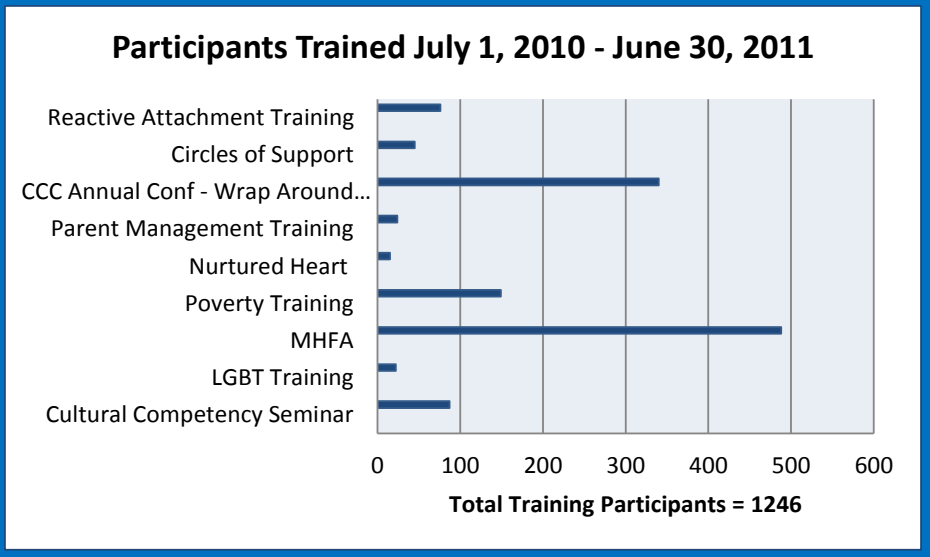
Support groups

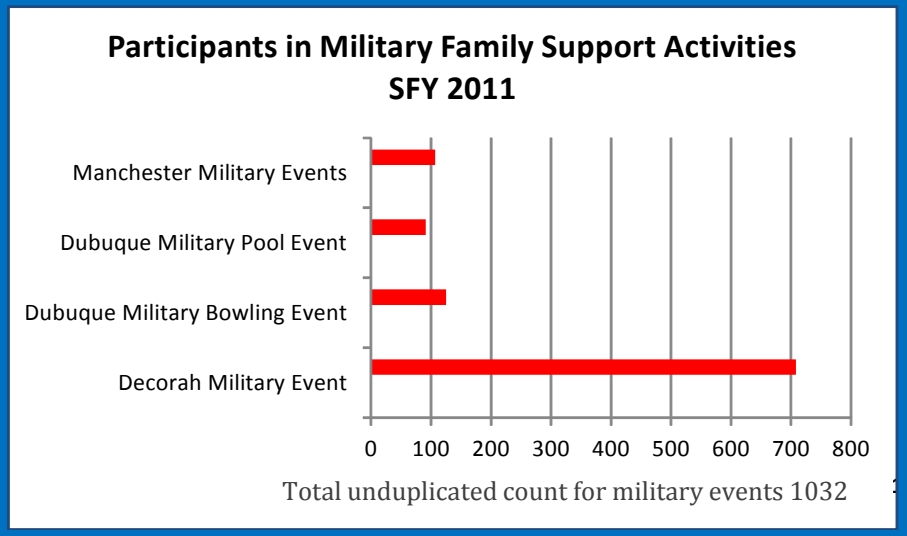
- Elevate/AMP
- Social Skill Building Groups
- Self Esteem Groups
- Anger Management Groups

Local Capacity Development and Systems Building









Agreements with partner agencies enforce SOC values

Revisions to Scope of Work. Prime Recipient reserves the right to make changes to the services to be provided which are within the Scope of Work, as shown in Attachment 5. Such changes and any added cost or cost reduction to Prime Recipient must be agreed to in writing and signed by Prime Recipient and Subrecipient prior to proceeding with any change.

Paperwork. Original copies of paperwork will be the sole property of the Subrecipient. Copies of paperwork needed by **CHSC or Community Circle of Care** (Prime Recipient) will be photocopied.

Audit Review. **DHS, SAMHSA, CCC and CHSC,** or any of their duly authorized representatives will have access, for the purpose of audit review and examination, to any documents, charts, and records of the Subrecipient pertinent to the services provided under this agreement.

System of Care Values. Subrecipient desires to be part of the Iowa System of Care expansion and will partner in the SOC expansion process lead by the Iowa Department of Human Services and Child Health Specialty Clinics. As such, the Subrecipient is committed to the following:

- Adherence too, teaching of, and infusion of System of Care Values and Principles within the Subrecipient organization and in the community, including all stakeholders, contractors and partners. Those values include:
  - Family Voice and Choice
  - Youth Voice and Choice
  - Strength Based
  - Culturally Competent
  - Team Based
  - Natural Supports
  - Individualized
  - Collaboration
  - Community Based
  - Persistence

Community Circle of Care - Initiatives

- Family to Family Certification Curriculum
- Positive Peer Connections
- STEP-IN
- Early Intervention Programs
- Training Initiatives (Parent Management Training, MHFA, Bridges Out of Poverty, Parent Doctor, 1-2-3 Magic, Psychological First Aid, Circles of Support, Behavior Doctor, the Nurtured Heart Parenting Approach, SOC Values, Wrap Around)
- Formed a local Federation of Families affiliated 501©3 **"The Family Circle"**
- Formed State of Iowa System of Care Resource Team
- Return to Medical Home
- Child and Youth Psychiatric Consult Program of Iowa.

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CHILD HEALTH SPECIALTY CLINICS
COMMUNITY CIRCLE OF CARE

Medical Homes: Must Include the Whole System of Care - **Teamwork**

- Patients and Families
- Primary care physicians
- Interdisciplinary health clinicians
- Specialists and subspecialists
- Hospitals and Healthcare Facilities
- Public Health
- Community

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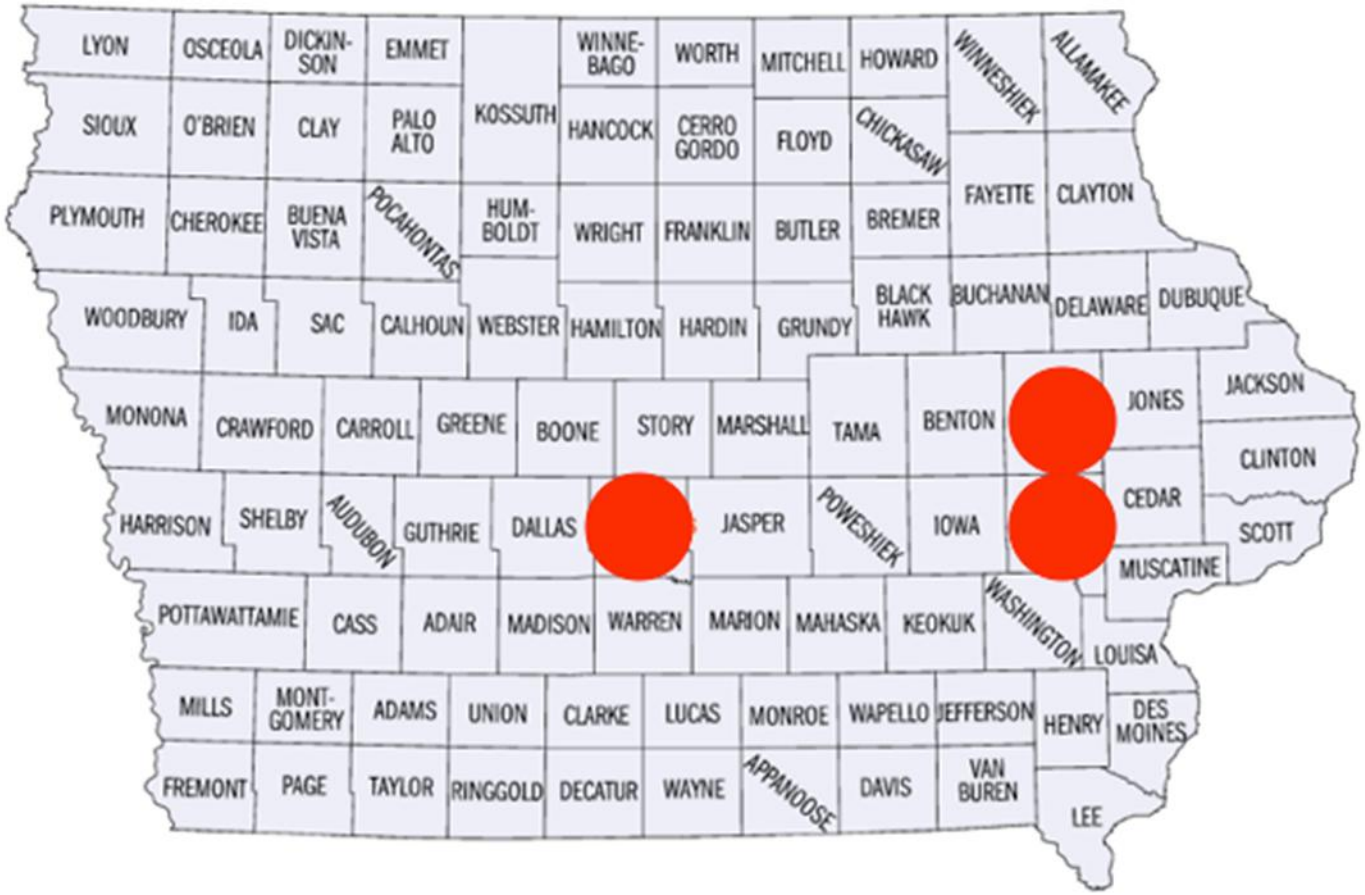

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CHILD HEALTH SPECIALTY CLINICS
COMMUNITY CIRCLE OF CARE

"While most children have access to primary care providers, child-trained behavioral health clinicians are scarce, particularly child psychiatrists. It will be difficult to meet the need for child behavioral health services without enlisting the assistance of primary care providers."

Thomas CR, Holzer CE III. The continuing shortage of child and adolescent psychiatrists. *J Am Acad Child Adolesc Psychiatry*. 2006;45(9):1023–1031
W. Holt, The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care, The Commonwealth Fund, March 2010.

Tools are being developed to help Primary Care Providers care for children with MH and behavioral concerns.

Children's primary care providers (PCPs) meet much of this need. For a number of years, they have been the most frequent prescribers of psychotropic medications, accounting for 85 percent of all such medications prescribed to children in 1997

R. Goodwin, M. S. Gould, C. Blanco et al., "Prescription of Psychotropic Medications to Youths in Office-Based Practice," *Psychiatric Services,* Aug. 2001 52(8):1081–87.

What does the program pay for?

Clinical Services

- 2 FTE - ARNP's
- 4 FTE - Social Work Care Coordinators
- 4 FTE – R.N. Care Coordinators
- 4 FTE - Parent Navigators
- 20 hour week Psychologist
- 16 hours a week Child Psychiatry
- 4 FTE Secretary
- 1 – 15 hours weekly Elevate Coordinator
- 20 hours a week child care

Systems Building

- 1 FTE Youth Coordinator
- 1 FTE Family Coordinator
- 1 - .5 FTE Social Marketer
- 1 - .5 FTE Cultural Competency Coordinator
- 1 FTE Project Director
- 1 FTE secretary
- 1 - .25FTE Medical Director
- 1 - .25FTE PhD Evaluator
- 1 FTE Evaluation Manager
- 1 FTE Data Collector

Community Circle of Care Service Statistics
SFY 2011

	Individuals Served	Services Type
New enrollments	504	Clinical Services (Includes assessment, diagnosis, intensive care coordination, and wrap-around community-based services)
Return patients	1063	Includes ARNP, psychiatry, and psychology visits
	1567	**Total served in clinics**
Support services	1246	Training activities
	1031	Military Families support activities
	135	Family support groups
	506	Youth activities
	189	Awareness activities *
	505	Information and Referral
	5,179	**Total Served ****

Community Circle of Care – Out of Home Placements SFY 2011

- **Foster care due to mental or emotional challenges (not due to safety)---------- 5**
- **Committed to Psychiatric Hospital (229)---------- 5**
- **Voluntarily admitted to Psychiatric Hospital--------- 5**
- **Entered In-Patient Substance Abuse TX---------- 4**
- **PMIC---------- 6**
- **Congregate Care/Residential TX---------- 3**
- **48 hour voluntary shelter placement/respite------- 8**

Total 36

Of the 1,567 youth served by CCC, in SFY11, 97% avoided out of home placement

DIAGNOSES OF CCC CHILDREN & YOUTH

- Consistent with the national System of Care Outcome Study, children receiving services through the Community Circle of Care are most likely to receive a primary diagnosis of an attention or conduct-related disorder or a mood disorder (depression/anxiety) at intake.
- The following slide shows the most common primary diagnoses among CCC children.

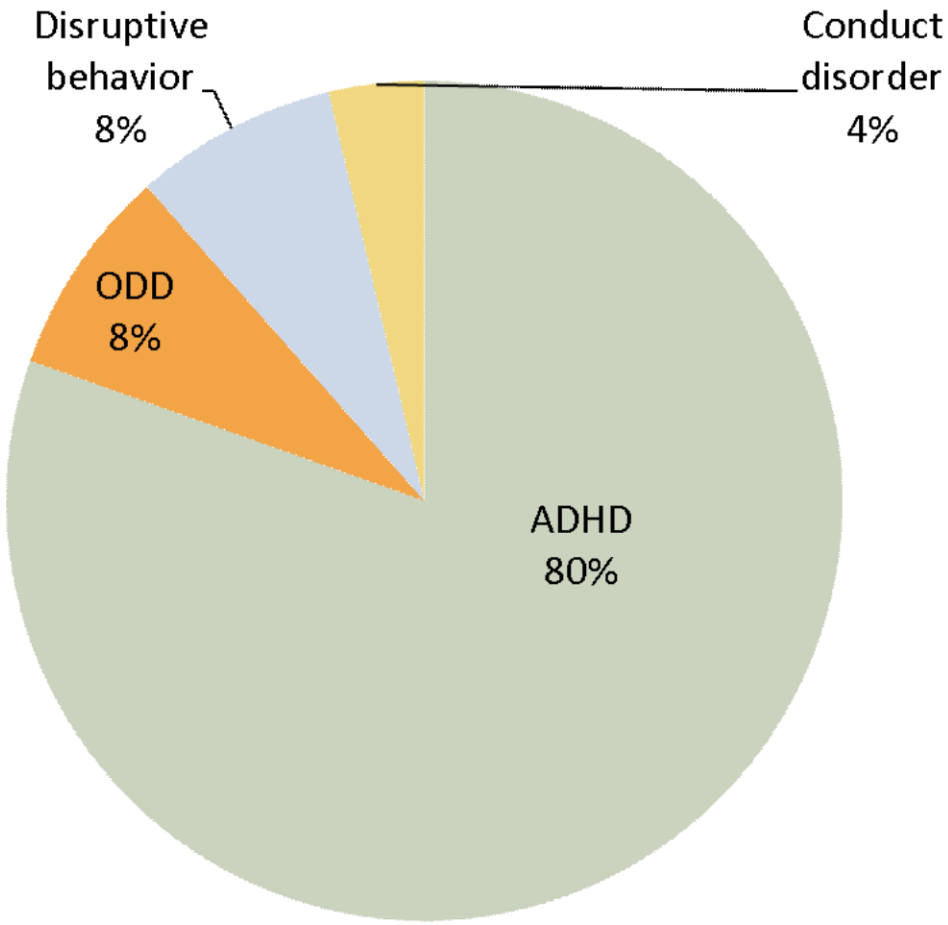
PRIMARY DIAGNOSIS

Primary Diagnosis of CCC Children & Youth at Intake (n = 755)		
Attention-Deficit and Disruptive Behavior Disorders *Includes Attention-Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Oppositional Defiant Disorder (ODD), and Disruptive Behavior Disorder*	572	75.4%
Depressive Disorders	66	8.7%
Anxiety Disorders	48	6.3%
Adjustment Disorders	34	4.5%
Pervasive Development Disorders *Includes Autistic Disorder, Asperger's Disorder, and other pervasive developmental disorders*	21	2.8%
Reactive Attachment Disorder	8	1.1%
Learning Disorders	6	0.8%
Other	4	0.6%

PREVALENCE OF ATTENTION-DEFICIT/DISRUPTIVE BEHAVIOR

- Over 75% of CCC youth receive a primary diagnosis of an attention-deficit or disruptive behavior disorder. This category includes the following:
  - Attention-Deficit Hyperactivity Disorder (ADHD)
  - Conduct Disorder
  - Oppositional Defiant Disorder (ODD)
  - Disruptive Behavior Disorder
- The following slide shows the frequency of each specific primary diagnosis among CCC children.

SPECIFIC ATTENTION-DEFICIT & DISRUPTIVE BEHAVIOR DIAGNOSES (N = 572)



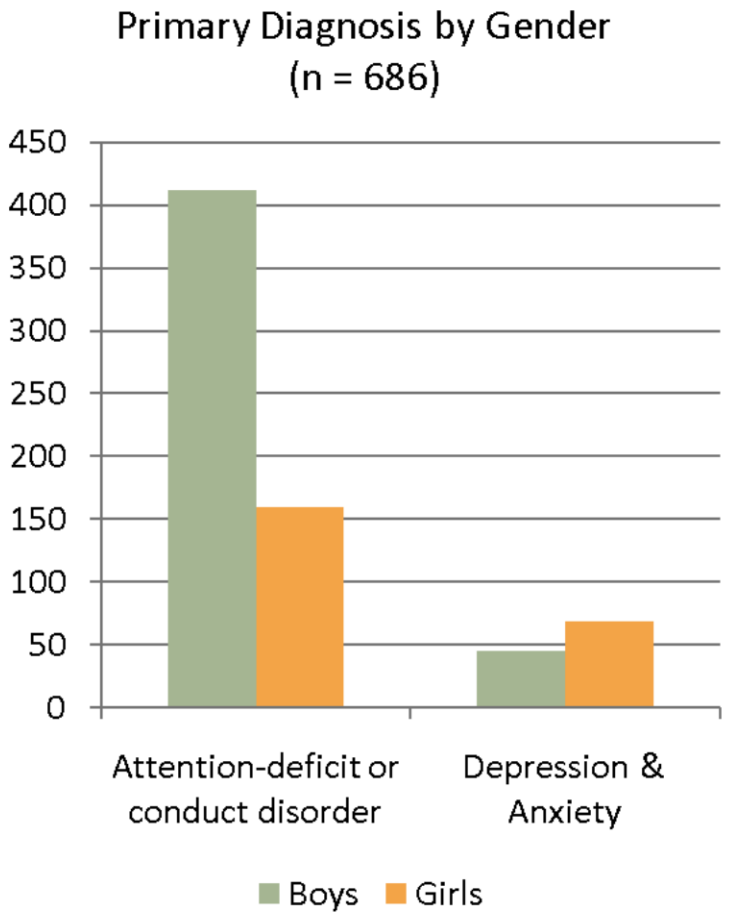
CO-OCCURRING ATTENTION-DEFICIT DIAGNOSES (N = 235)

- Nearly 60% of children served by CCC receive more than one diagnosis and 17% have three diagnoses.
- Of those with multiple diagnoses, 52% have two or more diagnoses within the attention-deficit/disruptive behavior category.

Diagnosis combination	No. of children	% of children
ADHD & ODD	190	81%
ADHD & Disruptive behavior	29	12%
ADHD & Conduct disorder	10	4%
ODD & Disruptive behavior	4	2%
ODD & Conduct disorder	2	1%

GENDER DIFFERENCES IN DIAGNOSES

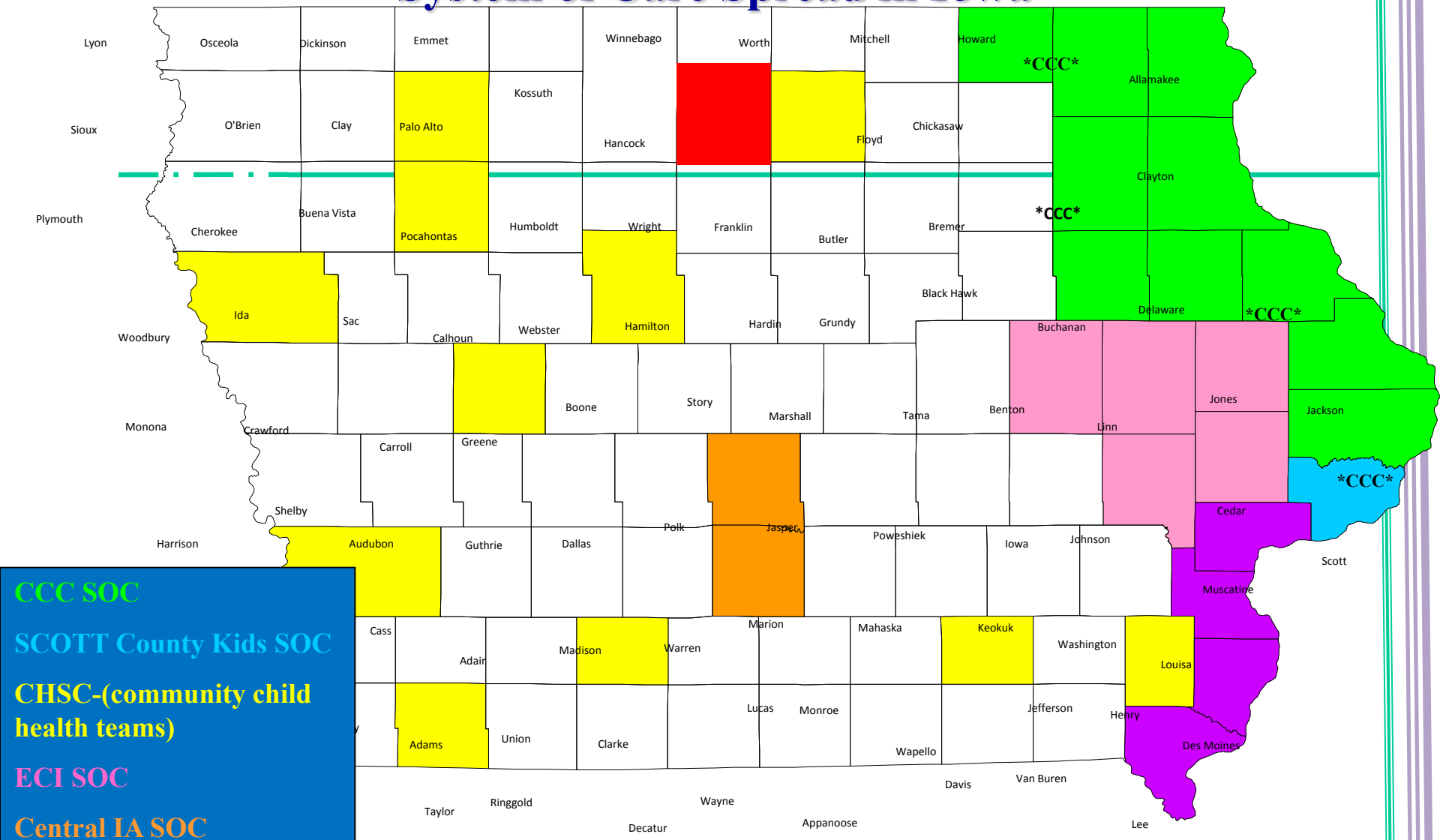
- Also consistent with national data, girls and boys tend to receive different primary diagnoses.
- Girls are more likely to be diagnosed with depression and/or anxiety.
- Boys are more frequently diagnosed with attention-deficit and conduct disorders.



Among families receiving CCC services for at least 12 months:

- ¨ 41% of youth showed improvement in school performance.
- ¨ 37% of youth showed improvement in school attendance.
- ¨ More caregivers reported positively about their child's ability to complete school-related tasks such as completing homework regularly and reading at or above grade level.
- ¨ Fewer caregivers reported missing days from work due to their child's behavioral or emotional problems.
- ¨ There was a 21% increase in the number of caregivers with a positive perception of their own self-functioning as parents of children with behavioral or emotional problems.

System of Care Spread in Iowa



CCC SOC

SCOTT County Kids SOC

CHSC-(community child health teams)

ECI SOC

Central IA SOC

Project LAUNCH

Mason City SOC

Interested in Starting SOC